Care@home – How a Virtual Care Service can support Primary Health Outcomes

This webinar will start shortly.

Care@home – How a Virtual Care Service can support Primary Health Outcomes

Zoom webinar – Tuesday 21 January 2025 - 6:30pm to 8:00pm

Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.

Learning outcomes

After this session, I will be able to:

- Develop awareness of the Care@home service
- Demonstrate how virtual care can support primary health goals
- Identify referral pathways into the appropriate Care@home service

Some housekeeping

- Tonight's webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
- Please don't forget to register for your next webinar at: https://www.primaryhealthtas.com.au/for-health-professionals/events/

Presenter(s)

1. Jane Palfreyman- Nurse Unit Manager Care@home
2. Samantha Shelley- Allied Health Navigator Virtual Complex Chronic Disease Management
3. Hannah Ward- General Practitioner Care@home
4. Laura Pyszkowski- EDON/Director of services, Home & Community Care

Care@home Expansion – PHT Primary Care Forum

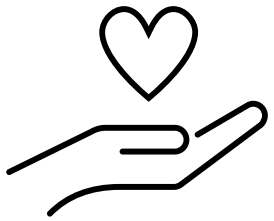
Jane Palfreyman (Care@home NUM)
Samantha Shelley (Care@home Allied Health Navigator)
Hannah Ward (Care@home GP)

Tasmanian Government | Department of Health

Objectives

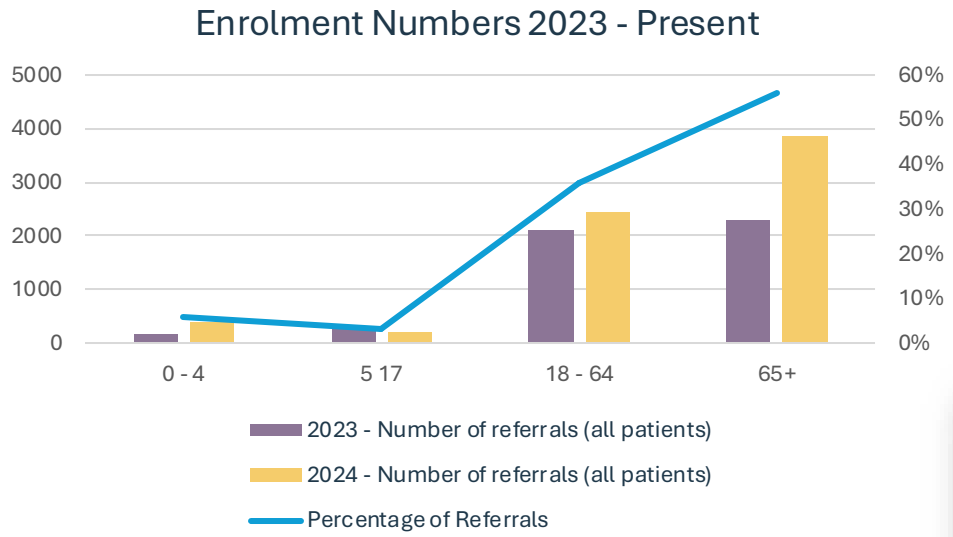
- Develop awareness of the Care@home service:
  - Remote monitoring for acute illness
  - Chronic Disease Management Program
  - GP Now
- Demonstrate how virtual care can support primary health goals
- Identify referral pathways into the appropriate Care@home service

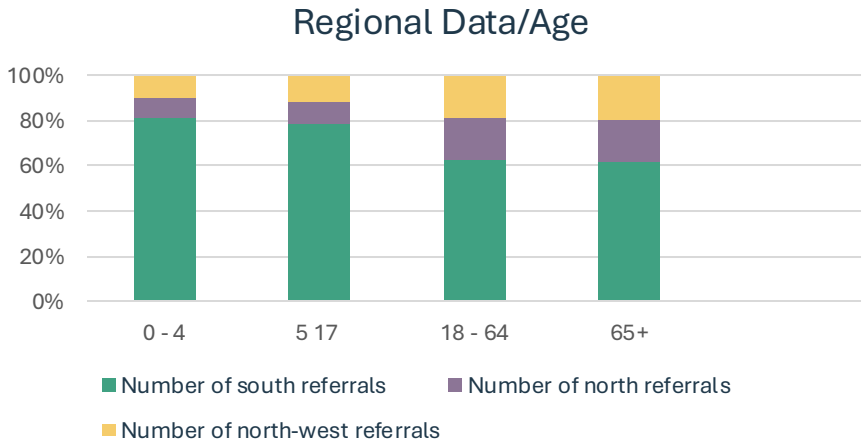
Who we are



Care@home is a **state-wide** interdisciplinary service that remotely supports patients, to better self-manage their illnesses and chronic conditions in their own home using virtual care technologies, improving patient health outcomes and reducing potentially preventable hospital admissions

Care@home Snapshot





Overall Satisfaction	Staff Explanation of Care	Treated with Respect & Dignity	Ease of Talking with Provider via Video	Hospital Avoidance
96.2%	96.5%	97.5%	94.5%	>5x

Why Change

- The Tasmanian health system is under pressure, with demand for our hospitals, ambulance and other services continuing to increase.
- Tasmania has higher self-reported level of multimorbidity when compared with their mainland counterparts, except the Northern Territory.
- Using the Australian Institute of Health and Welfare AIHW Chronic Condition multimorbidity classification, 5.3 per cent of the Tasmanian population in 2022–23 were multimorbid and had been admitted to hospital.
- Multimorbid admitted overnight patients, have an average length of stay of 8.1 days compared to 5.3 days nationally and are admitted on average 3.9 times per annum.
- Reporting from the AIHW demonstrates that people with chronic condition who do not see a GP when they need to are more likely to have potentially preventable hospitalisation.
- There is extensive evidence that demonstrates the value of virtual care in providing models of care that focus on hospital avoidance.

Why Now

Long Term Health Plan 2040

Tas DoH Strategic Priorities 2024 - 2028

Tas DoH Digital Health Transformation (2021-31)

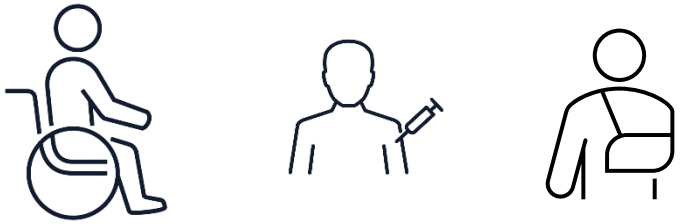
ED Review 2024

- The Long-Term Plan for Healthcare in Tasmania 2040 recognises the relevance of and need for providing hospital level care within people's place of residence and the community.

- This shift is driven by consumer preference to receive care at home when clinically appropriate, and the need to expand service delivery options to meet future demand for health care.

- Care@home is the next step on the journey as we optimise care at home building upon successful programs and providing expanded consumer choice.

Benefits



- Provide a flexible option for care when and where you need it.
- Care Integration and Coordination
- Empower consumers to better self-manage and understand your chronic conditions or illness.
- Improve communication between you and your health providers so they work better for you.
- Give you peace of mind, reassurance and a point of contact should you need at any time of the day.

- Reduces risk of emergency presentation and hospitalisations / re admission
- Support transition from acute hospital admission back to community care
- Reduction in length of hospital stay when transferred to Care@home
- Improved access to health care for our community
- Enhanced preventative management for chronic conditions
- Value Based Integrated care model across tertiary and primary care

General Eligibility Criteria

- Care can be safely delivered in the community setting using virtual technology
- The patient or medical decision maker consents to enrolment
- The patient has 24-hour access to a working telephone and able to use it to escalate care if required

May not be Eligible if

- They are medically unstable
- They have care needs that can be better provided by Primary Care or Tasmanian Health Service Community based services
- Their needs are better suited to hospital-based inpatient care, rehabilitation, or transition care.
- The patient or medical treatment decision-maker does not consent to the service.

If a patient is deemed unsuitable, the referring provider will be contacted, and Care@home staff will work with the referrer and patient to explore more appropriate options.

Care@home

Remote Monitoring for Acute Illness	Chronic Disease Management Program	GP Now
Supporting patients in the community to reduce risk of hospitalisation Supporting earlier hospital Discharge		**Offering short-term primary care deployment to community settings for at risk primary care services.**
Provides healthcare into a patient's home using virtual care technologies to support the management of short-term illnesses or conditions where clinical care can safely be delivered using virtual technology. Acute Respiratory Illness, Exacerbation of COPD, HF, Croup, Gastroenteritis	A focus on health coaching and care coordination, targeting those with the highest risk of hospital presentation or readmission with a diagnosis of Diabetes, Heart Failure, COPD and Post COVID-19 Syndrome. The service provides remote support and education for individuals to better manage their chronic conditions and improve overall health.	Provides General Practitioners who deliver clinical consultations as well as support for GP Registrars and junior doctors with supervision and training needs. Offering both virtual care support and short-term primary care deployment to community settings for at risk primary care services.

Enablers of Care – Digital Health, Workforce, Infrastructure & Integration

Remote Monitoring for Acute Illness

- Virtual Technology
- Expanding Patient Cohorts
- Communication and partnership with Primary Care

Care@home – CDMP

Virtual chronic disease support program focusing on:

- Health coaching
- Care navigation
- Care coordination

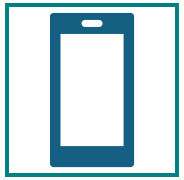
Target those with the highest risk of hospital presentation or readmission with a diagnosis of:

- Diabetes
- Heart Failure
- Chronic Obstructive Pulmonary Disease

Encompasses pre-existing Post COVID-19 Navigation Service and Cardihab

What does the program offer?

Individualised Program



Facilitation of services

Up to 3 months

Free

Care@home – CDMP

Health Coaching

- 7 dedicated health coaching sessions
- Improve health literacy, self-management and health awareness
- Identify health goals and provide coaching to support patients to achieve outcomes
- Foster independence by assisting patients to manage their own health care and minimise their risk of hospitalisations in the future

Care@home – CDMP

Care Navigation

Navigating people to the right care in the right place at the right time

Care Coordination

Improve the connection and communication between the patient and relevant health services

Care@home – CDMP

How do the Care@home team and GPs work together?

- The service will work with primary health providers including supporting established disease management plans
- Medical governance remains with the patient's primary GP
- Communication will be sent to GPs via HCS and be uploaded to patient's My Health record.

CDMP – Case Study

- Alice, 68 years old
- Self-referred
- Chronic Obstructive Pulmonary Disease (COPD)

Initial Ax

- No acute symptoms requiring intervention
- Hospital Admission Risk Program (HARP) Risk Calculator score: High Risk
- Alice consented to participating in health coaching, care coordination and care navigation.

CDMP – Case Study

Care Navigation Assessment

- No regular General Practitioner (GP)
- No action plan for COPD
- Current smoker
- Would benefit from domestic assistance
- High falls risk
- Not engaged with any community services
- Concerns with finances

CDMP – Case Study

Health Coaching Assessment

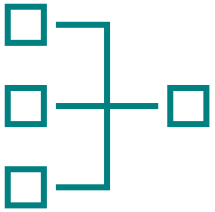
- SFI score: “poor”
- “Partners in Health” Scale
  - low self-management capacity in the areas of knowledge, working with healthcare providers to make decisions, keeping track of her symptoms and early warning signs.

CDMP – Case Study

Health Coaching Goals and Input

- Find and engage with a regular GP
- Recognise and act on signs of deterioration
- Know and understand COPD
- Know and understand medications
- Quit Smoking
- Start a regular exercise program

CDMP – Case Study



Program Completion

- Alice achieved her goals of understanding COPD and her medications, as well as recognising and acting on signs of deterioration.
- Plan in place for domestic and transport assistance
- Improved scores on the “Partners in Health” scale and SFI
- Continue to work on exercising and quitting smoking
- Communication with GP via consultation summary to the GP uploaded to My Health Record (MHR).

CDMP Referral Pathways

Self-Referral

Complete online enrolment form
Care@home (health.tas.gov.au)

OR

Phone **1800 973 363** to speak to a member of the admin team who will complete a referral on your behalf

TAS Secondary Triage

TAS Field Referral

HCP Referral (Community)

HCP Referral (Hospital)

Telephone

Phone **1800 973 363**

Select 2 for health care professional

eReferral – RMS

Referred to Site:
South - Community and Primary Health

Referred to Specialty: **Care@home**

Active for Internal THS ED / Outpatient Referrals

**Go Live for Primary Care December

Kyra

IQ Notes > Specialist Referral

insert relevant info

Email Notification to Nurse Coordinator

**Go Live December

Care@home - GP Now

Background

During the 2024 state election campaign, the Tasmanian Government announced as part of the 2030 Strong Plan, support for the primary care sector in Tasmania, including the establishment of a GP NOW Rapid Response team

GP's recruited locally and interstate

- Currently 0.8 FTE employed
- 3 further part time interstate GPs are starting in Feb

Care@home - GP Now

Project Objectives

- Create a Statewide GP Now Workforce which will enhance the delivery of primary care services to GP clinics in crisis and risk of closure due to inadequate medical staffing
- Provide supervision and support to junior doctors and GP Registrars when clinics are in crisis
- Provide emergent, urgent care in District Hospitals, Multi-Purpose Centres and RACF
- Provide support to Private Clinics, RACF, Multi-purpose Centres and District Hospitals
- Provide support to NWRH and MCH in crisis situation e.g. ED, Obstetrics

Care@home - GP Now

Collaborative Approaches to Solutions

- Linking Primary Care Practices with HR+ & PHT to explore all options
- Focus on long term sustainable approaches to Primary Care

Requests for assistance

- Contact GP Now through the Care@home email
- virtualcareprogram@health.tas.gov.au

Session Objectives Review

Remote Monitoring for Acute Illness	Chronic Disease Management Program	GP Now
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Enablers of Care – Digital Health, Workforce, Infrastructure & Integration

More Information

https://www.health.tas.gov.au/hospitals/carehome

1800 973 363: select option 2 to speak to a health care professional

careathomenursecoord@ths.tas.gov.au – Remote Monitoring for Acute Illness and CDMP inquiries

virtualcareprogram@health.tas.gov.au – GP Now inquiries

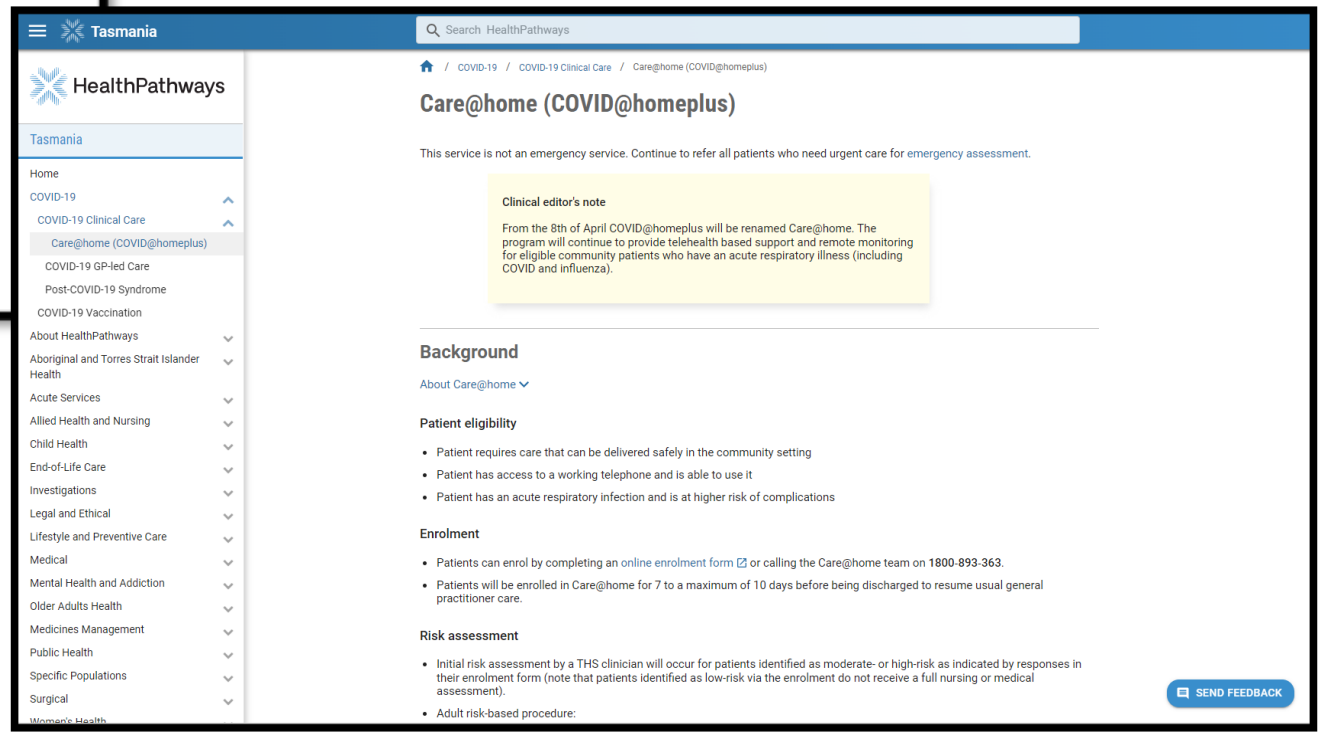
Tasmanian HealthPathways

Tasmanian HealthPathways is a web-based information portal developed by Primary Health Tasmania. It is designed to help primary care clinicians plan local patient care through primary, community and secondary healthcare systems.

For access to the Tasmanian HealthPathways, please email:

healthpathways@primaryhealthtas.com.au

Tasmanian HealthPathways



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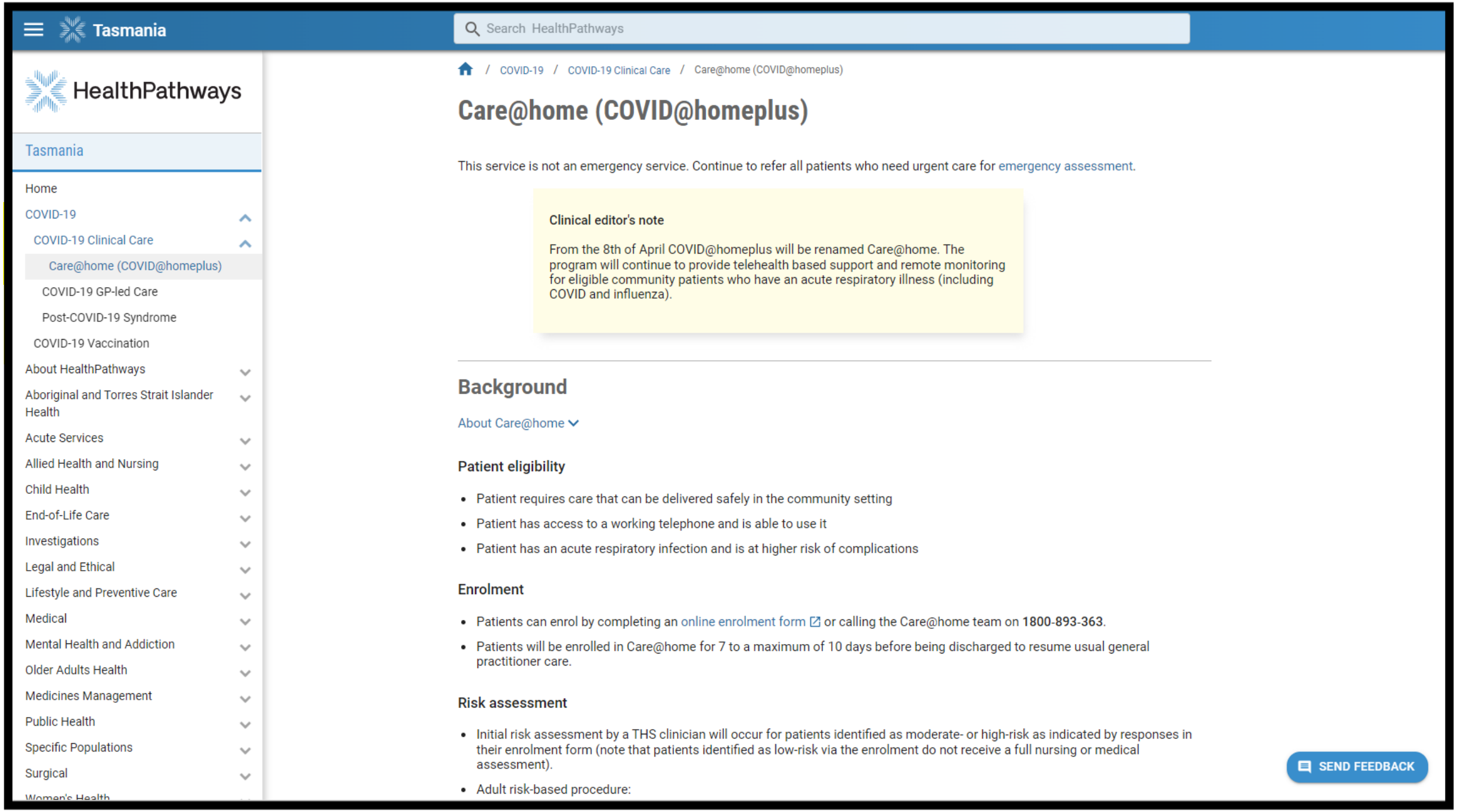
Tasmania
Search HealthPathways
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Tasmania
Home
COVID-19
COVID-19 Clinical Care
Care@home (COVID@homeplus)
COVID-19 GP-led Care
Post-COVID-19 Syndrome
COVID-19 Vaccination
About HealthPathways
Aboriginal and Torres Strait Islander Health
Acute Services
Allied Health and Nursing
Child Health
End-of-Life Care
Investigations
Legal and Ethical
Lifestyle and Preventive Care
Medical
Mental Health and Addiction
Older Adults Health
Medicines Management
Public Health
Specific Populations
Surgical
Women's Health
COVID-19 / COVID-19 Clinical Care / Care@home (COVID@homeplus)
Care@home (COVID@homeplus)
This service is not an emergency service. Continue to refer all patients who need urgent care for emergency assessment.
Clinical editor's note
From the 8th of April COVID@homeplus will be renamed Care@home. The program will continue to provide telehealth based support and remote monitoring for eligible community patients who have an acute respiratory illness (including COVID and influenza).
Background
About Care@home
Patient eligibility
Patient requires care that can be delivered safely in the community setting
Patient has access to a working telephone and is able to use it
Patient has an acute respiratory infection and is at higher risk of complications
Enrolment
Patients can enrol by completing an online enrolment form or calling the Care@home team on 1800-893-363.
Patients will be enrolled in Care@home for 7 to a maximum of 10 days before being discharged to resume usual general practitioner care.
Risk assessment
Initial risk assessment by a THS clinician will occur for patients identified as moderate- or high-risk as indicated by responses in their enrolment form (note that patients identified as low-risk via the enrolment do not receive a full nursing or medical assessment).
Adult risk-based procedure:
SEND FEEDBACK

Some final words

- After this webinar end, your browser will open a link to an evaluation survey.
- Statements of attendance will be emailed to participants.
- For event queries, please contact events@primaryhealthtas.com.au

Thank you

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